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ABSTRACT

An evaluation investigated the effectiveness of midwifery education in preparing midwives to care for clients likely to experience inequalities in health and/or inequalities in health care provision in England. The study was undertaken in these three phases: (1) literature review of midwifery and relevant social policy literature; (2) national survey of pre- and post- registration midwifery education; and (3) case site exploration of educational delivery and midwifery practice in three geographical locations (in the North, in Central England, and in the South of England). The research showed that many midwifery curricula emphasize inequalities issues in their philosophy, but that this emphasis is rarely followed through completely to curricula aims, learning outcome statements, education delivery, and assessment. The main conclusion was the need for a new approach to facilitate students and qualified midwives in developing an "inequalities imagination," which is a broad, inclusive, and creative conceptual tool within which midwifery educational initiatives and practice might be developed and evaluated. (YLB)

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Research Highlights 46

Evaluation of the Effectiveness of Midwifery Education in Preparing Midwives to Meet the Needs of Women from Disadvantaged Groups

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research

H I G H L I G H T S

Evaluation of the effectiveness of midwifery education in preparing midwives to meet the needs of women from disadvantaged groups

Abstract

This evaluation investigated the effectiveness of midwifery education in preparing midwives to care for clients likely to experience inequalities in health and/or inequalities in health care provision. The study was undertaken in three phases: (1) literature review of midwifery and relevant social policy literature; (2) national survey of pre- and post-registration midwifery education; (3) case site exploration of educational delivery and midwifery practice in three geographical locations, one in the North, one in Central England and one in the South. The research shows that many midwifery curricula emphasise inequalities issues in their philosophy, but that this emphasis is rarely followed through completely to curricula aims, learning outcome statements, education delivery and assessment. The main conclusion of the research is the need for a new approach to facilitate students and qualified midwives in developing an 'inequalities imagination': a broad, inclusive and creative conceptual tool within which midwifery educational initiatives and practice might be developed and evaluated.

Main Findings

Phase One: Literature Review

The review of health and social care literature showed that 'disadvantage' has been defined and explored in both 'structural' and 'individual' terms. The latter is more prevalent in midwifery. In comparison to the social work literature, which focuses on working with 'disadvantaged' individuals and groups, and which has a strong focus on anti-oppressive/anti-discriminatory practice, midwifery literature is generally unsophisticated in agendas related to disadvantage. Broader socio-political issues are rarely addressed. However, there is some consensus regarding key skills required by midwives who work with 'disadvantaged' clients. These include:

- an understanding of the social and cultural background of the woman
- an ability to advocate for the client
- an ability to overcome personal and societal prejudices
- an ability to practice in a reflexive manner

The literature reviewed suggests that the skills, knowledge and abilities which midwives need to care for 'disadvantaged' women are acquired during their whole career, rather than in the pre-registration period alone. This is endorsed by the UKCC in their *Fitness to Practice* report (UKCC 1999). However, there is currently no specific requirement in key professional documents for nurses, midwives or health visitors to address issues of inequalities in health in practice. While both the *UKCC Code of Professional Conduct* (UKCC 1992) and *The Midwives Rules* (UKCC 1998) hint at structural issues, the emphasis is on the 'appreciation' and 'recognition' of social, cultural and political contexts rather than on challenging discrimination and disadvantage.

Phase Two: National Survey of Midwifery Education

1. Pre-registration programmes

The pre-registration survey showed that

while midwifery educators, practitioners and students were usually well represented on the curriculum planning teams, there was a general lack of user representation. The programmes drew upon a range of professional and lay group contributors to the teaching, although members of local ethnic or religious groups were the least invited. Interest in, and attention to ethnic minorities was unevenly spread across institutions, and some made no reference at all to this client group's needs.

Within course philosophies, 'individualised' care, 'women-centred' care and 'holistic' care were umbrella terms under which inequalities were addressed. Similar concepts were evident within course and module aims but already the focus had narrowed to the level of individual needs to be met. Communication was the most frequently cited key skill required when addressing inequalities, and the most frequently reported attitudes required were a non-judgmental approach and self-awareness.

Although teaching strategies varied, the traditional lecture format was most commonly used. Reflection was reported in only two institutions out of the 25 which responded to the questionnaire. Most institutions could offer students at least one clinical placement with access to women who experience inequalities in health care/health care provision. However, as with the theoretical and practical assessments, a specific focus on inequalities was not compulsory.

2. Post-registration education

Relevant post-registration programmes were unevenly spread across the institutions surveyed. Four of the eighteen institutions, which responded to the post-registration questionnaire, accounted for just over half of the 112 post-registration initiatives reported. Specific client needs, such as socio-economic disadvantage, ethnic minority status, disability, teenagers and HIV/AIDS were mentioned in two-thirds of the initiatives.

The traditional lecture was the most frequently mentioned teaching strategy along with seminar and discussion groups.



Inequality issues were often taught without exploring the role of the midwife, particularly in the broader sociological and anthropological modules. Even in more midwifery specific modules, few initiatives actually identified specific skills and competencies required by midwives to better meet client's needs. As with the pre-registration findings, learning outcomes and assessments rarely required midwives to specify, assess or evaluate their own role in challenging inequalities or in meeting the needs of clients with specific disadvantages.

Phase Three: Case Site Studies

A clear understanding of the midwife's role, its boundaries and its relation to others in the multi-professional team were considered to be important across all sites, when dealing with issues of inequality. Many respondents deemed good communication and listening skills, together with a non-judgmental attitude to be crucial. Some written assessments were likely to address issues of inequality, however this focus was not compulsory.

Students in all three case sites reported the value of inviting user representatives into the classroom. This was felt to 'make real' specific inequality issues, thereby enhancing the students' understanding. In case sites A and B, students expressed dissatisfaction with the timing of the largely theoretical sociology module early in the course when they had minimal practical experience behind them. They were also concerned about the lack of specific midwifery issues and the inter-professional nature of this module. Lecturers across the sites generally agreed that it was desirable for students to experience a range of community practice placements in order to work with clients from diverse backgrounds. However, this was not always provided in practice. Respondents across the sites raised differences between the 'functional' nature of hospital midwifery versus the more 'holistic' style of midwifery practised in the community. Case sites B and C had link workers during office hours for some ethnic communities, but a need was expressed for these services to be extended

and for midwives to be more familiar with particular cultural mores.

1. Case site A was located in an area where there was an above-average ethnic minority population (9%) and relatively low levels of socio-economic deprivation. The small midwifery education department provided a three-year pre-registration midwifery course. Analysis of the curriculum documentation indicated that concepts of inequalities were introduced at an early stage, with the needs of specific groups being addressed later in the course. Both lecturers and students found 'reflection' a useful device for exploring inequalities issues, however, students became dissatisfied when reflection was used in an unfocused and non-systematic way. Students felt that lecturers needed to have recent experience of practice if they were to ensure that theory and practice were properly linked. At this particular site, 'equality of care' was generally agreed to mean meeting the specific needs of women and their families, in line with the philosophy of 'individualised care'. Central to this was knowledge of the social/cultural context of women's lives. Examples of unequal provision were reported in the care of non English-speaking service users, staff attitudes to young mothers and variable access to services such as the triple test which had to be paid for.
2. Case site B was based in an area that had relatively high levels of socio-economic deprivation, low ethnic minority population (4%) and a large midwifery education department. Both 18-month and three-year midwifery pre-registration courses were available at this site. The early part of the course introduced the students to concepts such as need, equity, choice and control in relation to practice. In addition, a link was made between complex social issues and health. Analysis of the curriculum indicated a strong feminist agenda, together with a focus on Changing Childbirth (DoH, 1993). There was little mention of 'individualised care' in relation to 'equality of care'; rather the



emphasis was on social class and local geographical inequalities. Clients identified as 'disadvantaged' in this case site included 'teenage mums', disabled and ethnic minority women. Some service users, community midwives and students gave accounts of hospital midwives showing a lack of awareness and understanding regarding the social realities of women in their care. In particular, judgmental attitudes towards teenagers and drug users were cited.

3. Case site C was located in an area with high levels of socio-economic deprivation and a large ethnic minority population of 42%. The site had a low midwife to woman ratio, a high number of midwifery vacancies and difficulties recruiting bank/agency staff. The medium sized midwifery education department provided an 18-month pre-registration midwifery programme. Curriculum analysis revealed that the philosophy and aims strongly reflected the needs of local diverse groups; ethnicity and cultural issues were threaded throughout. Almost all modules and theoretical assignments made specific reference to inequalities in health/health care provision. Language was a key issue for the midwifery service as approximately 80% of clients belonged to one of a range of ethnic minorities. Many respondents felt that language barriers presented a huge obstacle to the delivery of 'equality of care'. The bilingual health advocacy service was recognised as important by many midwifery respondents, but some doubted the veracity of translations and this led to tensions between midwives and advocates. While aware of these concerns, advocates saw their role less as mere translator and more as empowering agent. Midwives often mentioned the need to refer disadvantaged clients on to other agencies.

'Individualised' or 'women centred' care was rarely mentioned, instead, respondents talked about 'equality of care' in terms of constraints or as rhetoric that did not exist in practice. The ethnic mix amongst midwives was considerable and some suggested that different midwifery

religious and cultural perspectives, when espoused strongly, might be oppressive for staff and clients who held different views, and could lead to conflicting advice. Some clients expressed openly racist views about some midwives. Women complained about poor support with breastfeeding and language difficulties, as well as rude and impatient staff. Students felt strongly that they had received considerable input on inequality issues, but possibly at the expense of basic knowledge such as physiology. Managers reported having insufficient mentors to cover practice placements, and students were concerned about inadequate support in practice.

Conclusion

Developing an 'inequalities imagination'

The main conclusion of the research was the need for a new model to facilitate students and qualified midwives in developing an 'inequalities imagination'. This is offered as a broad, inclusive and creative conceptual tool within which midwifery educational innovations and practice might be developed and evaluated. The concept is reminiscent of the notion of the 'sociological imagination' expounded by one of the 'founding fathers' of sociology, Wright Mills (1959). It draws on notions such as culturally competent care, cultural safety, anti-discriminatory and anti-oppressive practice. In particular, Campinha-Bacote's model of the process of developing cultural competence (1999) is adapted and expanded to provide a framework within which to explore professional practice in relation to disadvantaged clients.

The development of an 'inequalities imagination' involves a move away from practitioners and educators having to make a choice between facts and experience, theory and practice, or art and science/rationality towards a way of maintaining both sides of these dualisms at all times. The concept can complement the notion of 'individualised care'. It implies thinking beyond the limited notion of what the individual client wants or



needs, to a more informed and creative approach that recognises the factors that determine needs in contemporary society. This new concept implies a 'loosening up' amongst midwives that would enable them to acknowledge the difficulties involved in working with clients with whom they find it difficult to empathise. 7

Method

Critical realism, grounded theory and reflexivity constitute the major theoretical and methodological influences on the study. The evaluation consisted of three phases:

1. Review of midwifery literature focused on issues regarding women with 'specific needs'/disadvantaged women' and set within the context of contemporary social policy. The review also considered the role of the midwife in the context of wider health and social care.
2. National survey of midwifery education using two postal questionnaires aimed at pre- and post-registration education provision, respectively. The questionnaires were sent to 46 midwifery education departments. A total of 25 pre-registration questionnaires (54% response rate) and 18 post-basic questionnaires (39% response rate) were returned. A sample of curriculum documents was obtained from nine institutions for triangulation purposes.
3. Three 'case site' studies of both education delivery and midwifery practice were undertaken to explore the links between curriculum, theory and practice. The sites were carefully chosen to provide a range in levels of deprivation, geographical spread and size of education department. The sites were in the Centre, the North and the South of England. Case study and stakeholder evaluation methods were used during the case sites. Fieldwork comprised of a series of interviews with midwifery students, preceptors, service users, midwifery service managers and midwifery tutors. Focus groups, classroom observation and informal observation of practice were also undertaken. A total of 264 hours of interview and observation data were collected across the three case sites. Informed consent was sought, and confidentiality assured.

Analysis of case site data started with categorisation and coding of emergent issues. The researchers then 'progressively focused' on areas which illustrated key issues relating to the midwifery education and practice in the context of work with disadvantaged clients. A process of participant validation was used and participants were invited to document their views on the findings, possible recommendations and accuracy.

The research team comprised six individuals, three social scientists and three midwives. Two of the midwives had an academic background in social science and the other had a background in education. Each team member had their own set of prior assumptions, personal and professional backgrounds. The multidisciplinary nature of the team, while increasing the complexity of project administration, reaped benefits from a broad research skill base and a higher level of conceptual thinking.



Further information

For copies of the Research Highlights and the Report, please contact:
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Project details

This two year research project, commissioned by the English National Board for Nursing, Midwifery and Health Visiting, was undertaken between September 1998 and August 2000.

The findings of the project will be of particular interest to those involved in the design and delivery of pre- and post-registration midwifery programmes, together with managers, professionals, students, teachers and policy makers in the field of midwifery. It will also be of interest to nursing educators and practitioners interested in inequalities in health care provision.

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Final Report

The final report will be published through the Board's Researching Professional Education Series in Summer 2001. Copies may be purchased through the Publications Department listed above.

RESEARCH HIGHLIGHTS

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